| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065196 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Malley Transitional Care Center | 401 Malley Dr<br>Northglenn, CO 80233 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262<br><br>Based on observation, record review, interview, and policy review, the facility failed to 1.) maintain a comfortable temperature for residents in their rooms and hallway for two of three units (West unit and the East unit), and 2.) maintain the residents' wheelchairs in a condition that was in good repair. Specifically, the wheelchair arms for seven of 78 residents' wheelchairs (Resident (R) 64, R239, R8, R240, R1, R118, and R117) were cracked and missing vinyl exposing the white material underneath. This failure prevented the cleaning and sanitizing of the wheelchair arm rests.<br><br>Findings include:<br><br>1.<br><br>a. Interview on 09/23/24 at 12:03 PM, R24 stated that her room gets hot and that she needs to use her fan. She stated that the room is not air conditioned (AC) and that the AC was in the hallway.<br><br>Review of R24's electronic medical record (EMR) Care Plan tab revealed R24's annual Minimum Data Set (MDS), with an assessment referent date of 06/20/24, indicated a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicating the resident's cognition was intact.<br><br>b. Interview on 09/23/24 at 12:11 PM, R1 stated that her room was hot, and she has to use her fan.<br><br>Review of R1's EMR Care Plan tab revealed a quarterly MDS, with an ARD of<br><br>08/22/24, which indicated a BIMS score of 15 out of 15, indicating the resident's cognition was intact.<br><br>c. Interview on 09/23/24 at 1:30 PM, R40 stated that it was very hot in her room last night.<br><br>Review of R40's EMR Care Plan tab revealed a quarterly MDS, with an ARD of 07/25/25, which indicated a BIMS score of 15 out of 15, indicating the resident's cognition was intact.<br><br>d. Review of R94's admission MDS, with an ARD of 07/23/24 and located in the resident's EMR section titled MDS, documented that the resident was cognitively intact and able to make decisions for herself.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 09/23/24 at 11:15 AM revealed R94's room was stifling hot. There was no air coming from the air conditioning vents.<br><br>During an interview with R94 on 09/23/24 at 1:30 PM, the resident stated that her room was hot as hell. R94 noted that she had complained several times to the staff and the Administrator, but nothing was ever done.<br><br>Interview with the Director of Nursing (DON) on 09/23/24 at 1:42 PM, the DON stated the rooms do not have AC in them and that the hallways have the AC.<br><br>Interview with the Maintenance Director on 09/23/24 at 2:43 PM, he confirmed that the residents' room do not have AC and that the AC was in the hallways. The Maintenance Director stated that when he checks the residents' hot water temperature in their bathrooms, he notices if the rooms are hot. He stated that he does not have any documentation of checking the residents' ambient room temperatures.<br><br>During an interview on 9/24/24 at 11:10 AM, Certified Nursing Aide (CNA) 5 revealed the night shift usually turned the heat on at night because it was too cold, and the day shift must turn the heat off in the morning.<br><br>During the tour of the residents' rooms throughout the facility and the thermostats on each hallway at 09/25/24 at 4:30 PM, the following observations were made of the thermostats.<br><br>Observation on the [NAME] unit of the thermostat near room [ROOM NUMBER]B, revealed it was turned off. The Maintenance Director stated when the thermostat is turned off, there is no AC in that hallway and that causes the rooms on that hallway to feel warm. When the Maintenance Director turned on the thermostat and the AC came on, the hallway was 79.0 degrees Fahrenheit (F).<br><br>Observation on the [NAME] unit of the thermostat in the hallway outside of the beauty shop, revealed it was turned off. When the Maintenance Director turned on the thermostat and there was AC, the temperature in the hallways was 77 degrees F.<br><br>Observation of the East unit nurses' station revealed the thermostat was turned off, and when the Maintenance Director turned on the thermostat and there was AC, the temperature was 75.0 degrees F.<br><br>Review of the facility's policy titled, Safe and Homelike Environment, dated 2024 and provided by the Administrator indicated, . 7. The facility will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees F .<br><br>2. During the tour of the facility on 09/25/24 at 4:30 PM, the following observations were made of the residents' wheelchair arm rests:<br><br>R64, R239, R8, R240, R1, R118 and R117's wheelchair arm rests were cracked, exposing the white material below.<br><br>Interview with the Maintenance Director on 09/25/24 at 4:53 PM, he stated that the Rehabilitation department or restorative nursing was responsible for the replacement of the damaged wheelchair arm rests.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's policy titled, Wheelchair Management, dated 03/2024 and provided by the Administrator, indicated, . 5. The facility will maintain the wheelchair by providing maintenance as needed . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015<br><br>Based on interviews, record review, and facility policy review, the facility failed to ensure allegations of abuse were reported per the federal regulations to the Colorado Department of Public Health and Environment (CDPHE) within two hours of the facility being made aware of the abuse allegations for three of three residents (Residents (R) 61, R237, and R387) reviewed for allegations of abuse out of a total sample of 31.<br><br>Findings include:<br><br>Review of the facility's policy titled, Abuse: Prevention of and Prevention Against, revision date of 10/2022, revealed, . Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to appropriate State or Federal agencies in the applicable timeframes . and applicable regulations .<br><br>1. Review of R61's undated Face Sheet, located in the electronic medical record (EMR) under the Profile tab, indicated R61 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, and dementia without behavioral disturbance.<br><br>Review of R61's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ADR) of 08/22/24, revealed R61 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS indicated the resident did not exhibit any behaviors.<br><br>Review of R61's Care Plan, dated 12/05/22, revealed R61. utilizes [medication name] for diagnoses of depression. She has times where she can have extreme mood fluctuations that can cause increased angry and tearfulness . Interventions included, . assist with a program of activities that is meaningful and of interest . assist to identify strengths, positive coping skills, and reinforce these . R61 had not been cared planned for behaviors, including making false accusations.<br><br>During this surveyor's Resident Council meeting, conducted on 09/25/24 at 1:53 PM, R61 requested to speak with this surveyor privately when questioned if any of the staff make you feel uncomfortable. Upon the conclusion of the meeting, this surveyor met with R61 in private, on 09/25/24 at 3:08 PM. R61 stated that she had seen Certified Nurse Aide (CNA) 3 and CNA4 come out of her room, and when she went into her room, there was water all over the sink and floor. R61 stated she went back out to the hallway and yelled at CNA3 and CNA4 to please clean up their mess next time. R61 stated CNA3 yelled at her, Would you like for me to pee all over your sink, and you can clean that up? When questioned if R61 had reported this to the administration, she replied Yes. R61 was visibly upset and crying over the incident. R61 stated that she had reported this to Registered Nurse (RN) 4, who asked her what she wanted to be done and suggested they file a grievance. When asked if she recalled how long ago this happened, R61 stated she thought it had been a year or two ago.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R61's Grievance Report, provided by the facility, indicated the report was made on 08/26/23 at 1:00 PM. The detail description of concern documented, Resident stated she asked [CNA3] to clean up the water around the sink in her room after they used it and he turned around while she was in the bathroom and said, 'should I just pee all over your sink and floor, would you like that?' Resident said she was upset and asked him to leave.<br><br>During an interview on 09/25/24 at 5:15 PM, the Administrator stated the incident had not been reported to the State agency. The Administrator was asked to review the initial report of the alleged incident. The Administrator stated, Just looking at the initial comments on the grievance report, it does appear to be an allegation of verbal abuse and should have been reported to the state. The facility reported the incident on 09/25/24 at 7:00 PM.<br><br>2. Review of R237's Profile tab of the EMR reviewed R237 was admitted to the facility on [DATE] and discharged on ,d+[DATE].<br><br>Review of R237's admission MDS, with an ARD of 04/15/24, revealed R237 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>Review of the facility's investigative documentation revealed that on 07/20/24 between 12:00 AM to 2:00 AM, R237 did not recall the exact time, R237 stated that she thought she heard LPN3 down the hallway near the nurses' station state, Get out of my face or I will hit you. At 8:00 AM-8:30 AM, R237 informed the weekend supervisor, Registered Nurse (RN) 4 about the allegation of verbal abuse regarding the night nurse, LPN3.<br><br>The Administrator reviewed the Colorado (CO) State Agency's (SA) website which indicated that the facility's Social Service Director (SSD) notified the CO SA on 07/20/24 at 11:35 AM and the Occurrence number was 24020432015.<br><br>Interview on 09/26/24 at 01:43 PM, the SSD confirmed by looking at the CO SSA website that the allegation of verbal abuse was reported to the SA on 07/20/24 at 11:30 AM, which was three hours after R237 reported to staff the allegation of verbal abuse.<br><br>3. Review of R387's undated Face Sheet, located in the EMR under the Profile tab, indicated R387 was initially admitted to the facility on [DATE], with a readmission on diagnoses including vascular dementia without behavioral disturbance, cognitive communication deficit, and aphasia.<br><br>Review of R387's admission MDS, located in the EMR under the MDS tab and with an ARD of 01/07/24, revealed R387's BIMS score was 00 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS indicated R387 was assessed as not exhibiting any behaviors.<br><br>Review of R387's Care Plan, dated 11/09/23, indicated R387 was . at risk for worsening/impaired cognitive function/dementia or impaired thought processes r/t [related to] new environment and diagnoses of vascular dementia. [Resident name] at time will become agitated with staff's redirection for safety concerns. He can yell and cuss at staff .<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Facility Reportable Incident (FRI), dated 01/09/24 and provided by the facility, documented, . [CNA2] was coming down hallway and witnessed nurse shut her med cart and turned to resident stating 'stop spitting on the floor that's f**king nasty.' Upon further investigation other staff report that resident was going behind nurse station and [name withheld] was redirecting him. Resident became verbally aggressive with her and was calling her names such as 'bitch'.<br><br>Further review of the FRI indicated the incident occurred on 01/08/24 at 8:00 PM and was submitted on 01/09/24 at 5:12 PM to the CDPHE.<br><br>During an interview on 09/26/24 at 12:53PM, RN1 stated that she had not been in the facility at the time of the incident since it happened on night shift, but the incident had been reported to her on 01/09/24, the next day, at change of shift. RN1 stated CNA3 reported that Licensed Practical Nurse (LPN) 3 got into the face of R387 and yelled at him. RN1 stated she did feel this was an allegation of verbal abuse, so she immediately told LPN4, North Unit Manager.<br><br>During an interview on 09/26/24 at 1:06 PM, LPN4, the North Unit Manager, was asked what she did when she was informed about R387's incident. LPN4 stated that she turned the grievance over to the Director of Nursing (DON) at that time, who was no longer employed at the facility.<br><br>During an interview on 09/26/24 at 5:30 PM, the Administrator was asked if he was aware of the incident with R387. The Administrator stated he did not recall the incident but confirmed that the allegation of verbal abuse should have been reported immediately. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>29015<br><br>Based on record review and interview, the facility failed to ensure two of two residents and their representatives (R) 86 and R109) reviewed for facility initiated emergent hospital transfer from a total sample of 31 residents were provided with written transfer/discharge notices that contained the required information. This failure had the potential to affect the residents and their Resident Representative (RR) by not having the knowledge of how to appeal the transfer, if desired, and how to notify the State Long-Term Care (LTC) Ombudsman's office.<br><br>Findings include:<br><br>1. Review of R86's electronic medical record (EMR) Progress Notes in the Progress Notes tab revealed, . 03/11/24 at 3:48 AM, Resident . reported that he wasn't feeling well . BP [blood pressure] was 123/72, HR [heart rate] 132 Temp [temperature] 101.3 O2 [oxygen] 75% on 5L [5 liters] resp [respirations] 28 . orders to send to ER [emergency room ] . Paramedics took resident to [hospital] .<br><br>Review of R86's EMR Progress Notes in the Progress Notes tab indicated, . 03/13/24 at 11:32 PM, res [resident] back from the hospital .<br><br>2. Review of R109's EMR Progress Notes in the Progress Notes tab indicated, . 08/03/24 at 5:27 PM, Suprapubic catheter continues to leak . paramedics contacted to transfer patient to ER for replacement . EMT [Emergency Medical Technician] here at approximately 6:30PM to take patient to ER .<br><br>Interview on 09/25/24 at 2:01 PM, the Director of Nursing (DON) stated that when residents are discharged to the ER, the nurses send the Medical Orders for Scope of Treatment (MOST), Power of Attorney (POA) document, and face sheet with the resident, and if staff have time, they would print the transfer form, labs pertinent to the situation, and progress notes.<br><br>Interview on 09/25/24 at 3:10 PM, the Social Service Director (SSD) provided the list of transfers that were sent to the State LTC Ombudsman's office. The SSD confirmed that neither R86 nor R109's hospital transfers were included on the list. The SSD stated that only transfers to home or death were sent to the State LTC Ombudsman's office.<br><br>Interview on 09/25/24 at 5:00 PM, the DON provided a copy of R86 and R109's Transfer Form that was sent with the residents at the time of their transfer to the hospital. The DON reviewed the document and confirmed that neither transfer document included the resident's appeal rights nor the information regarding the State LTC Ombudsman office. The DON confirmed that the facility did not have a policy regarding facility initiated transfers and notification of the State LTC Ombudsman's office. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752<br><br>Based on interview and record review, the facility failed to complete a significant change in status Minimum Data Set (MDS) for one of one resident (Resident (R) 121) reviewed for hospice in a total sample of 31 residents. This had the potential to cause unmet care needs for R121.<br><br>Findings include:<br><br>A review of R121's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses including stage IV sacral pressure ulcer and osteomyelitis of the vertebra, sacral and sacrococcygeal area.<br><br>A review of R121's Order Summary Report, located in the resident's EMR under the Orders tab, revealed the following order, dated 04/07/24: admitted to [Hospice Name Withheld] with diagnosis of Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region.<br><br>A review of R121's EMR revealed a quarterly MDS, with an Assessment Reference Date of 06/18/24 and located in the MDS tab of the EMR, which documented the resident was receiving hospice services. A significant change in status MDS was not completed until 07/03/24.<br><br>During an interview on 09/26/24 at 11:39 AM, the MDS Coordinator (MDSC) confirmed that since R121 was placed on hospice in April, a significant change assessment should have been completed at least two weeks later. The MDSC stated that she was on vacation during that period, and it was overlooked; however, the significant change MDS was completed in July. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>16752<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to secure one of two medication carts on the East Wing when out of the site of the nursing staff. This failure could permit individual unauthorized access to residents' medications.<br><br>Findings include:<br><br>A review of a facility document titled, Medication Access and Storage, E kit access, with a revision date of 04/2024 read in part, Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.<br><br>Observation on 09/25/24 at 4:47 PM revealed the medication cart on the East wing was left unlocked at the nurses' station. There were no staff members present at the nurses' station. Residents (R) 8 and R22 were around the unlocked medication cart. R8 sat in a wheelchair across from the cart, and R22 propelled herself up next to the cart. Registered Nurse (RN) 3 returned to the unit and went to the bathroom. RN3 returned to the nurses' station and started talking to another staff member. R22 remained close to the unlocked medication cart. RN3 obtained a drinking cup from the cart and went into the medication room. The medication cart remained unlocked. RN3 returned carrying a drinking cup with clear liquid and gave it to R22. RN3 then briefly returned to the nurses' station without locking the medication cart. RN3 then got up pulled the medication drawer open and started to set up evening medications. The medication cart was unlocked for seven and one-half minutes.<br><br>A review of R8's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/24 and located in the resident's electronic medical record (EMR) under the MDS tab, revealed R8 had severely impaired cognition.<br><br>A review of R22's quarterly MDS, with an ARD of 07/09/24 and located in the resident's EMR under the MDS tab, revealed the resident's cognition was intact and was able to make decisions.<br><br>An interview on 09/25/24 at 5:10 PM with RN3 revealed that she did not realize that she had left the medication cart unlocked. RN3 stated that she had left the unit to escort a resident to the dining room. RN stated that R22 was alert and oriented and was waiting for her evening drink. RN3 acknowledged that R8 was cognitively impaired and did not think that the resident could propel herself over to the medication cart.<br><br>An interview was conducted on 9/25/24 at 5:30 PM with the Unit Care Coordinator Licensed Practical Nurse (LPN)1. LPN1 stated it was an expectation that the medication would always be kept locked when not in use. LPN1 stated it did not matter whether a cognitively intact or cognitively impaired resident was in the area; an unlocked cart would be a safety issue. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015<br><br>Based on observations, interviews, record reviews, and review of facility policy, the facility failed to 1.) follow current standards of practice related to the use of personal protective equipment (PPE) with transmission-based precautions and/or implement their policy and procedures related to enhanced barrier precautions (EBP) for two of two residents (Resident (R) 107 and R389) reviewed for transmission-based precautions out of a total sample of 31, and 2.) sanitize glucometers in a manner that prevented cross-contamination for one of three residents (R76) observed receiving fingerstick blood glucose tests (FSBG). These failures had the potential to lead to the spread of infection throughout the facility.<br><br>Findings include:<br><br>Review of the facility's policy titled, IPCP Standard and Transmission-Based Precautions, revised 03/2024, revealed, Droplet Precautions (TBP) are used for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking (e.9. influenza). Implement source control by placing a mask on the patient. Ensure appropriate patient placement in a single room if possible. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives. Use personal protective equipment (PPE) appropriately. [NAME] mask (and eye protection if indicated) upon entry into the patient room or patient space. Limit transport and movement of patients outside of the room for medically necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette. Implementation: a. The facility will implement a system to alert staff, residents, and visitors that a resident is on Transmission Based Precautions (TBP). Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) ii. For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves b. Make PPE, including gowns and gloves, available immediately outside of the resident room, or for EBP gown and gloves can be available inside the room to promote dignity and quality of life. c. Ensure access to alcohol-based hand rub d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room e. Provide education to residents and visitors as needed.<br><br>A review of the undated facility's document titled, Glucometer Disinfection, reads in part . create a clean . perform hand hygiene . disinfect the glucometer for with Micro kill disinfectant wipes for one minute . actively wipe the machine for one minute and let the glucometer air dry on a clean surface .<br><br>1. Review of R389's undated Face Sheet, located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility from the hospital on 09/20/24 with diagnoses including malignant neoplasm of main bronchus, chronic obstructive pulmonary disease, and irritable bowel syndrome with diarrhea.<br><br>Review of R389's hospital's undated Discharge Notes, located in the EMR under the Miscellaneous tab, revealed the resident had tested positive for COVID-19 on 09/12/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065196 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Malley Transitional Care Center | 401 Malley Dr<br>Northglenn, CO 80233 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During the facility's initial tour conducted on 09/23/24 at 11:56AM, an observation was made of R389's room. There was a sign on R389's door, indicating the resident was on droplet precautions; instructing staff and visitors to wear N95 mask, gloves, gowns, and googles or face shield; and to keep door closed.<br><br>During an observation made on 09/23/24 at 11:56 AM, R389's door was left open.<br><br>During observations conducted on 09/23/24 at 12:25 PM, and 12:30 PM, Certified Nurse Aide (CNA) 1 was observed going into and out of R389's room without the appropriate PPE, except for a surgical mask.<br><br>During an interview conducted with CNA1 on 09/23/24 at 12:31PM, CNA1 was asked what she was supposed to wear to go into R389's room. CNA1 responded, I normally just wear a mask. CNA1 was asked why R387 was on droplet precautions. CNA1 stated, I was told it was for COVID; guess I should have been wearing goggles and gown.<br><br>During an interview conducted with the Administrator on 09/23/24 at 12:50 PM, the Administrator stated he would expect whoever enters an isolation room to follow the precaution signs.<br><br>During an interview conducted with the Director of Nursing (DON) on 09/23/24 at 1:51 PM, the DON was asked what her expectations were of staff and isolation residents. The DON responded, Staff should be aware of who is on isolation and what PPE is supposed to be worn.<br><br>During observations conducted on 09/24/24 at 9:52 AM, 11:04 AM, and 3:39 PM revealed R389's room was no longer on isolation. R389 was observed to have an indwelling urinary catheter. There was no PPE available, and there was no signage to indicate the resident was on EBP, as per the facility's policy.<br><br>During an interview with LPN2 on 09/24/24 at 4:28 PM, LPN2 confirmed R389 was supposed to be on EBP, and that there was no PPE or sign on the door.<br><br>During an interview with the Infection Preventionist (IP) on 09/24/24 at 5:00PM, the IP was asked if R389 was supposed to be on EBP. The IP confirmed that there was not an EBP sign or PPE on 389's door. The IP stated that it was her fault, that she forgot to hang the sign and PPE on the door.<br><br>25490<br><br>2. Review of R107's Face Sheet, located in the EMR under the Profile tab, revealed that R107 was originally admitted to the facility on [DATE] with the diagnoses that included chronic respiratory failure with hypoxia, anoxic brain damage, and muscle wasting.<br><br>Review of R107's Physicians Order, located in the EMR under the Orders tab and dated 05/27/24, revealed, . on Enhanced Barrier Precautions . related to having a tracheostomy and gastrostomy tube.<br><br>Review of the EBP sign located on R107's door revealed, . wear gloves and gown for the following high care areas dressing, bathing showering .<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 09/23/24 at 11:29 AM revealed CNA1 was already in the room providing incontinent care. CNA1 wore gloves but did not wear a gown as per facility policy related to EBP precautions.<br><br>During an interview on 09/23/24 at 11:37 AM, CNA1 confirmed she was not wearing a gown while providing incontinent care to R107. CNA1 stated she did not don a gown because she was in a hurry. She stated she had received infection control training, and that the purpose of EBP is to prevent the spread of infections.<br><br>16752<br><br>3. An observation on 09/25/24 at 5:00 PM revealed RN3 preparing to perform a FSBG test on R76. RN3 did not disinfect the glucometer before using it on R76. Once RN3 obtained the blood glucose test, she returned to the medication cart, created a clean field, obtained a Micro Kill Germicidal wipe, and wiped the glucometer for ten seconds. She then started putting the glucometer back in the medication cart drawer, stopped and wiped the glucometer for a few more seconds, wrapped the glucometer in the Micro Kill Wipe, and placed the wrapped glucometer inside the medication cart drawer.<br><br>An interview was conducted on 09/25/24 at 5:33 PM with RN3. RN3 stated that she disinfected the glucometer that morning after testing the resident's blood glucose, and the glucometer had not been used since that time. RN3 stated she did not see the need to disinfect the machine before the evening fingerstick blood glucose check. RN3 stated that she was unsure of how long the glucometer should be wiped down with the germicidal wipe.<br><br>An interview with Unit Care Coordinator Licensed Practical Nurse (LPN) 1 was conducted on 09/25/24 at 5:53 PM. LPN1 stated it was an expectation that glucometers be disinfected before and after each resident use. LPN1 stated the nurse is expected to perform hand hygiene, create a clean field, and use the Micro Kill One Germicidal Wipe, wiping the machine down for a full minute, and then leaving the machine to air dry. |